National Tribal Consultation Forum

Health and Human Services Follow Up to tening Councils

Department of Health and Human Services

Renaissance Mayflower Hotel

Washington, DC
July 19-20, 2000

National Tribal Consultation Forum

The US Department of Health and Human Services (HHS) is hosting a National Tribal Consultation Forum to be held July 19-20, 2000 in Washington, D.C. The objective of the meeting for HHS to respond to the issues raised by American Indian and Alaska Native tribal leaders during the five Regional Listening Councils that were held across the country in 1998 and 1999 by Deputy Secretary Kevin Thurm and the Indian Health Service Director, Dr. Michael Trujillo.

The Listening Councils presented an opportunity for tribal leaders to engage in consultation with HHS. The Deputy Secretary and Indian Health Service Director heard directly from tribal leaders about the challenges confronting Indian people, particularly those related to the provision of health and human services. During the National Tribal Consultation Forum:

-HHS agencies will describe actions that have been taken on specific issues raised during the Listening Councils

-HHS agencies will discuss with tribal leaders actions to address remaining issues from the Listening Councils

-Tribal leaders will provide input to HHS and HHS agencies' consultation plans and continue collaborative efforts with HHS to implement and institutionalize the HHS tribal consultation process

-Tribal leaders will obtain current information about HHS programs

National Tribal Consultation Forum

Contents

National Tribal Consultation Forum

Draft Agenda

Wednesday July 1 9, 2000

Grand Ballroom (Promenade Level)

8:00-8:30 am	Continental Breakfast
8:30-8:3S am	Introduction of Davis *Carol Martin, Senior Advisor, Tribal Affairs*
8:35-8:45 am	Blessing-Julia Davis, Nez Pierce Tribe
8:45-9:00 am	Welcome and Introductions *John Callaban, Assistant Secretary for Management and Budget*
9:00-9:30 am	Opening Remarks: *Michael H. Trujillo, MD, IHS Director* *Kevin Thurm, DHHS Deputy Secretary*
9:30-10:30 am	Follow Up **to** Listening Councils Issues/Recommendations *Andy Hyman, Director, Office of Intergovernmental Affairs* Panel 1: Administration for Children and Families Agency for Toxic Substances and Disease Registry Centers for Disease Control and Prevention Health Care Financing Administration Substance Abuse and Mental Health Services Administration
10:30-10:45 am	Break
10:45-12:00 pm	Panel 1: Dialogue/Questions and Answers *H. Sally Smith, Moderator* *Chairperson, National Indian Health Board*

Operating Divisions

Administration on Aging (AOA)

The Administration on Aging leads the nation in creating the shared vision that aging is a process, not a point in time. AoA calls people of all generations to healthy, productive and secure aging.

This role leads to two essential tasks. One is to serve well the 43 million seniors through the objectives and programs of the Older Americans Act. The second is to plan ahead for the doubling of that population by bringing to bear the resources of this Department and the Administration.

Administration for Children and Families (ACF)

The Administration for Children and Families (ACF), within the Department of Health and Human Services (I-IHS) is responsible for federal programs which promote the economic and social well-being of families, children, individuals, and communities. Through its federal leadership, ACF sees: families and individuals empowered to increase their own economic independence and productivity; strong, healthy, supportive communities having a positive impact on the quality of life and the development of children; partnerships with individuals, front-line service providers, comrnunities, American Indian tribes, Native communities, states, and Congress that enable solutions which transcend traditional agency boundaries; services planned, reformed, and integrated to improve needed access; and a strong commitment to working with people with developmental disabilities, refugees, and migrants to address their needs, strengths, and abilities.

Agency for Healthcare Research & Quality (AHRQ)

The Agency for Healthcare Research and Quality (AHRQ was established in 1989 as the Agency for Health Care Policy and Research. Reauthorizing legislation passed in November 1999 establishes AHRQ_as the lead Federal agency on quality research. AHRQ, part of the U.S. Department of Health and Human Services, is the lead agency charged with supporting research designed to improve the quality of health care, reduce its cost, and broaden access to essen- tial services. AHRQs broad programs of research bring practical, science-based information to med- ical practitioners and to consumers and other health care purchasers.

Agency for Toxic Substances and Disease Registry (ATSOR)

The mission of the Agency for To@dc Substances and Disease Registry (ATSDR), as an agency of the U.S. Department of Health and Human Services, is to prevent exposure and adverse human health effects and diminished quality of life associ-

ated with exposure to hazardous substances from waste sites, unplanned releases, and other sources of pollution present in the environment.

ATSDR is directed by congressional mandate to perform specific functions concerning the effect on public health of hazardous substances in the environment. These functions include public health assessments of waste sites, health consultations concerning specific hazardous substances, health surveillance and registries, response to emergency releases of hazardous substances, applied research in support of public health assessments, infbrmation development and dissemination, and education and training concerning hazardous substances.

Centers for Disease Control and Prevention (CDC)

The mission of the Centers for Disease Control and Prevention is to promote health and quality of life by preventing and controlling disease, injury, and disability. CDC Pledges to the American people:

To be a diligent steward of the fends entrusted **to it.**

To provide an environment for intellectual and personal growth and integrity.

To base all public health decisions on the highest quality scientific data, openly and objectively derived.

To place the **benefits** to society above the benefits **to** the institution.

To treat all persons with dignity, honesty, and respect.

Food and Drug Administration (FDA)

The Food and Drug Administration touches the lives of virtually every American every day. For it is FDRs job to see that the food we eat is safe and wholesome, the cosmetics we use wont hurt us,
the medicines and medical devices we use are safe and effective, and that radiation-emitting products such as microwave ovens wont do us harm. Feed and drugs for pets and farm animals also come under FDA scrutiny. FDA also ensures that all of these products are labeled truthfully with the information that people need to use them properly.

Health Care Financing Administration (HCFA)

The Health Care Financing Administration (HCFA) is a federal agency within the U.S. Department of Health and Human Services. HCFA runs the Medicare and Medicaid programs --two national health care programs that benefit about 75 million Americans. And with the Health Resources and Services Administration, HCFA runs the Children's Health Insurance Program, a program that is expected to cover many of the approximately 10 million uninsured children in the United States.

HCFA also regulates all laboratory testing (except - research) performed on humans in the United States. Approximately 158,000 laboratory entities fall within HCFKs regulatory responsibility. And HCFA, with the Departments of Labor and Treasury, helps millions of Americans and small companies get and keep health insurance coverage and helps eliminate discrimination based on health status for people buying health insurance.

Health Resources and Service Administration (HRSA)

The Health Resources and Services Administration (HRSA) directs national health programs that improve the Nation's health by assuring equitable access to comprehensive, quality health care for all. HRSA works to improve and extend life for people living with HIV/AIDS, pro- vide primary health care to medically underserved people, serve women and children through State programs, and train a health workforce that is both diverse and motivated to work in underserved communities. -The Access Agency's accomplishrnents for the past fiscal year are detailed in the HRSA Annual Report 1999.

Indian Health Service (IHS)

The Indian Health Service (IHS), an agency with- in the U S Department of Health and Human Services, is responsible for providing federal health services to American Indians and Alaska Natives. The provision of health services to members of federally recognized tribes grew out of the special government to government relationship between the United States federal government and Indian tribes. This relationship, established in 1787, is based on Article 1, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders.

The IHS is the principal federal health care provider and health advocate for Indian people, and its goal is to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people. The IHS currently provides health services to approximately 1.5 million American Indians and Alaska Natives who belong to more than 550 federally recognized tribes in 35 states.

National Institutes of Health (NIH)

The NIH mission is to uncover new knowledge that will lead to better health for everyone. NIH works toward that mission by: conducting research in its own laboratories; supporting the research of non-Federal scientists in universities, medical schools, hospitals, and research institutions throughout the country and abroad; helping in the training of research investigators; and fostering communication of medical information.

Program Support Center (PSC)

The Program Support Center (PSC) is an Operating Division (OPDIV) within the Department of Health and Human Services (HHS). Our mission is to provide qualitative and responsive 'support services" on a cost-effective, competitive, 'service-for-fee" basis to HHS components and other Federal organizations and agencies. This distinctive, self-supporting operation brings a pioneering business-like enterprise approach to Government support services.

Our objective is to enhance the productivity, quality and responsiveness of Governmental organizations with administrative support service responsibilities and to be 'Number One' in customer service. We have the experience, expertise

and skills to provide these services to achieve your mission in a climate of changing and challenging national priorities and diminishing resources. Look to the Program Support Center as a national resource for accountability, value, innovation,
vision, and leadership in human resources, financial management, and administrative operations.

Substance Abuse and Mental Health Services Administration (SAMHSA)

The Substance Abuse and Mental Health Services Administration is the Federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitation services in order **to** reduce illness, death, disability, and cost to society resulting from substance abuse and mental ifl-nesses.

Staff Divisions

Office of Public Health and Science (OPHS)

The Office of Public Health and Science (OPHS) is under the direction of the Assistant Secretary for Health, who serves as the Senior Advisor on public health and science issues to the Secretary of Health and Human Services (HHS). The Office serves as the focal point for leadership and coordination across the Department in public health and science; provides direction to program offices within OPHS; and provides advice and counsel on public health and science issues to the Secretary.

Office of the Assistant Secretary for Management and Budget (ASMB)

The Office of the Assistant Secretary for Management and Budget (ASMB) provides the highest quality advice and service in administrative and financial management to the Secretary and all the Department of Health and Human Services components.

Office of the Assistant Secretary for Planning and Evaluation (ASPE)

The Assistant Secretary for Planning and Evaluation (ASPE) is the principal advisor to the Secretary of the U.S. Department of Health and Human Services on policy development, and is responsible for major activities in the areas of policy coordination, legislation development, strategic planning, policy research and evaluation, and economic analysis.

Office of the General Counsel (OGC)

The Office of the General Counsel (OGC) has an extraordinarily interesting agenda, both because of the breadth of the Department's activities and because the issues on which lawyers work are the national issues of the day. Over the past decade, welfare and health care reform have been central concerns for the country and are likewise central focuses of the work of OGC. Other recent issues addressed by OGC include tobacco regulation, fetal tissue research, breast implants, Native American tribal self-determination, Head Start, needle exchange, organ donation and transplantation, federally-funded abortion, programs for the aging, affirmative action in science training, and nursing home quality of care enforcement. Work in this office provides the opportunity to do rewarding and fascinating public service and public interest law.

Office of Civil Rights (OCR)

The Department of Health and Human Services, through the Office for Civil Rights, promotes and ensures that people have equal access to and opportunity to participate in and receive services in all HHS programs without facing unlawful discrimination. Through prevention and elimination of unlawful discrimination, the Office for Civil Rights helps HHS carry out its overall mission of improving the health and well being of all people affected by its many programs.

This mission is communicated throughout the Department and is reflected in the customer service nondiscrimination objectives that have been developed in the Department's strategic plan. Ensuring the nondiscriminatory provision of services funded by or provided directly by the Department is a continuing challenge to all of the Department's employees.

Office of intergovernmental Affairs (IGA)

As part of the Immediate Office of the Secretary, our mission is to facilitate communication regarding Health and Human Services (HHS) initiatives as they relate to state and local governments. IGA is the Departmental liaison to state governments, and serves the dual role of representing the state perspective in the federal policymaking process as well as clarifying the federal perspective to state representatives. In facilitating state and federal communications, our office works directly with the states, as well as with several organizations representing state and local governments.

The Office of the Assistant Secretary for Legislation (ASL)

The Office of the Assistant Secretary for Legislation provides advice to the Secretary and the Department on congressional legislation and facilitates communication between the Department and Congress. The Office of the Assistant Secretary for Legislation (ASL) is responsible for the development and implementation of the Department's legislative agenda and is the liaison with members of Congress and their staffs. The Office informs the Congress of Departmental priorities, actions, grants and con- tracts. The Office of the Assistant Secretary for Legislation is divided into four parts - the Immediate Office of the Assistant Secretary; Office of Health Legislation; Office of Human Services Legislation; and the Office of Congressional Liaison.

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National Tribal Consultation Forum

Draft Summary Report

Department of Health and Human Services

Tribal Government Listening Councils

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Executive Summary

The U.S. Department of Health and Human Services (HHS) invited tribal leaders to participate in a series of five regional Listening Councils held throughout the United States during 1998 and 1999. These Listening Councils were an important step in developing and maintaining Government-to-Government relations and meaningful consultation which had been defined in Secretary Donna E. Shalala's August, 1997 memorandum, "Department Policy on Consultation with American Indian/Alaska Native Tribes and Indian Organizations." The Listening Councils were as follows:

Location	Date	# Participants	Region
Scottsdale, AZ	**Oct.** 14,1998	32	S/CA, AZ, NV, UT, CO, NM
Bismarck, ND	Dec. 4,1998	35	MT, WY, ND, SD, MN, WI, IA
Seattle, WA	Jan. 21, 1999	56	AK, WA, **OR, ID, N/CA**
Oklahoma City, OK	March 9,1999	104	OK, KS, NE, TX
Syracuse, NY	May 21, 1999	19	NY, ME, MA, RI, CT, NC, **SC,** MS, AL, LA, FL

Tribal leaders or their designees were asked to participate in the Listening Councils with Mr. Kevin Thurm, Deputy Secretary for HHS and Dr. Michael Trujillo, Director of the Indian Health Service (IHS). Representatives of Indian organizations were provided time to make comments at the conclusion of remarks by elected tribal leaders. Upon reviewing the transcripts from the five Listening Councils, 52 distinct issue areas were identified and were divided into seven major themes:

1. Funding and Budget Issues
2. Services and Service Provision
3. Care Providers
4. Facilities, Equipment and Supplies
5. Intergovernmental Relations and Related Issues
6. Infrastructure
7. Data and Research

Each of the issues was assigned to one or more HHS agencies. In most instances the agencies provided specific information about underlying federal laws and authorities regarding the issue, current and proposed activities to address the issue, obstacles preventing actions and strategies to overcome obstacles. In addition, there were a few issues raised by participants that dealt with concerns outside the jurisdiction of the HHS. The Office of the Secretary has referred these to the appropriate federal department or agency.

This Summary Report briefly describes the **five** Listening Councils. In addition, it identifies the major themes and crosscutting or national issues, as well as the local or regional issues, which emerged. The focus of this report specifically responds to crosscutting issues.

Introduction

In April 1994, President Clinton issued a memorandurn for the heads of executive departments and agencies entitled, 'Government-to- Government Relations with Native American Tribal Governments," reaffirming the unique legal relationship that has long existed between tribal governments and the federal government. This relationship is founded upon a long legal history and affirmed in treaties, the U.S. Constitution, federal statutes and Supreme Court decisions. The President's Memorandum specifically described the responsibilities of each federal department and agency **to** honor this Govemment-to-Govemment relationship by establishing an appropriate consultation policy.

In her August 1997 policy memorandum entitled, 'Department Policy on Consultation with American Indian/Alaska Native (Al/AN) Tribes and Indian Organizations,' HHS Secretary Shalala expressed her expectation that the 'intent and spirit of the President's Memorandum is fully embraced in the consultation process." The memorandum defined 'consultation' as follows:

Consultation is an enhanced form of communication which emphasizes trust, respect and shared responsibility.
It is an open and the exchange of information and opinion among parties, which leads to mutual under- standing and comprehension. Consultation is integral to a deliberative process which results in effective collaboration and informed decision making.

Therefore, the Secretary directed the Department **to:**

1. Consult with Indian people to the greatest practicable extent and to the extent permitted by law before taking actions that affect these governments and people;

2. Assist States in the development and implementation of mechanisms for consultation with their respective tribal governments and Indian organizations before taking actions that affect these govemments and/or the Indian people residing within their State. Consultation should be conducted in a meaningful manner that is consistent with the definition of 'consultation' as defined in this policy including reporting to the appropriate HHS agency on its findings, and on the results of the consultation process that was utilized;

3. Assess the impact of this Department's plans, projects, programs and activities on tribal and other available resources;

4. Remove any procedural impediments to working directly with tribal governments or Indian people; and

S. Work collaboratively with other Federal agencies in these efforts.

Accordingly, Secretary Shalala initiated a series of five regional Listening Councils with representatives of tribal governments and other Indian organizations. Representing the Secretary at the region- al Listening Councils were Deputy Secretary Kevin Thurm and Dr. Michael Trujillo, Director of the Indian Health Service (11-IS). Elected leaders and official representatives of tribal governments were asked to address specific health and human service issues or concerns. Thus, the Listening Councils provided tribal leaders with the opportunity to hear about the Department's policy on tribal consultation and for the Department to hear from Tribes about their concerns with HHS policies and programs. In sum, the purpose was to answer this question:

What do we need to do together, the Federal Government and Tribal Governments, to help bring the _Promise of health, well being and opportunity to American Indians and Alaska Natives?

Part I-Description of Five Listening Councils

Scottsdale, Arizona, October 14, 1998

The Scottsdale Listening Council, which was moderated by Anthony Largo, spokesperson for the Santa Rosa Band of Cahuilla Indians in California, included tribal leaders from Southern California, Arizona, Nevada, Utah, Colorado and New Mexico. Approximately 32 individuals participated. The meeting began with introductions by each tribal leader and Dr. Trujillo and Deputy Secretary Thurm made introductory remarks to begin the discussion. Time was provided for tribal leaders wishing to make a statement, first on mat- ters related to health, then on matters related to human services. A significant portion of the time at Scottsdale focused on the consultation process and how to make it more effective and meaning- ful. The Scottsdale participants wanted to confirm the steps involved in meaningful consultation and the feedback that they could expect from these Listening Councils. Forty-three individual issues and recommendations were identified during the Scottsdale meeting, most of which were 'crosscut- ting' or national in focus. Deputy Secretary Thurm and Dr. Trujillo made a site visit to the Gila River Indian Community.

RegionaL / Local Issues

The issues that were of local or regional significance included: the decrease in Medi-Cal reimbursements in California and the gap in funding it created for tribal and urban Indian health care providers; the allocations of new funds under the THS Diabetes Initiative, specifically that California Tribes may be receiving an inequitable distribution; the need for funding to replace the Phoenix Indian Medical Center in Phoenix, Arizona (this facility has been on the IHS facility construction priority list); the need for funding to replace the Fort Defiance Indian Hospital on the Navajo Reservation; the need for a hospital facility to serve the Tribes in Nevada, who are located too far away from the Phoenix Indian Medical Center to access that facility; the need for facility construction funding for California Tribes; and multigenerational exposure to uranium mining and its related hazardous effects.

Crosscutting Issues

The participants at the Scottsdale meeting raised concerns about the HHS consultation process and, in particular, the Administration's commitment to the process. In particular, it was recommended that the Secretary establish an 'Indian Desk7 in the Office of the Secretary. Strong support was voiced for the existing IHS Budget Formulation and the manner in which it involves tribal consultation throughout. There was considerable discussion about consultation, a theme that resonated in the four listening councils that would follow. In addition, participants recommended that the self-governance process be made permanent for the

IHS, and that Contract Support Cost funding not be allocated on a pro rata basis. It was also recommended that HHS apply the provisions of the Indian Self-Determination and Education Assistance Act (PL. 93-638), contracting of programs, to all agencies within the Department, not only the IHS.

Other issues included: concerns about the amount of funding for all IHS programs and services and the process through which funding is allocated by the IHS; the lack of support for home- and community-based care for patients with disabilities; the distribution of resources within the IHS system; the need to focus more funding and services on alcoholism and substance abuse, the elderly, youth, accident prevention, emergency medical services, complications from chronic diseases, such as diabetes, and the recruitment and retention of qualified Indian health professionals; concerns about the inadequacy of facilities and infrastruc-, ture and, specifically, the need for new or refurbished outpatient and inpatient facilities and sanitary water and updated sewer systems for Indian communities; the difficulty Tribes experience with reimbursement for services available through Medicare and Medicaid; the need for technical assistance to enable them to more effectively secure reimbursement for eligible patients; assistance in coordinating with State managed care systems and improving third party billing; concern was expressed about the new welfare reform system, Temporary Assistance to Needy Families (TANF). Finally, participants voiced strong concern that the federal government fulfills its trust responsibility by providing the quality and quantity of health care needed by Tribes.

Bismarck, North Dakota, December 4, 1998

The Bismarck Listening Council included tribal leaders from Montana, Wyoming, North Dakota, South Dakota, Minnesota, Wisconsin and Iowa. Dr. David Gipp, President of the United Tribes Technical College, served as the moderator for this meeting. Approximately 35 individuals made presentations at the Bismarck meeting. The day before the Listening Councils, Deputy Secretary Thurm and Dr. Trujillo made a site visit to the Youth Center and Senior Center in Eagle Butte, SD.

Regional / Local Issues

The vast majority of issues and recommendations raised by tribal leaders and others at the Bismarck meeting were of national significance; however, several issues raised were unique to the region. One concern raised by several participants was that treaty tribes were not receiving an equitable distribution of IHS resources and that health status indicators, which reflect severe health problems among the Northern Plains Tribes, such as infant mortality, are not adequately incorporated into allocation decisions. Tribal leaders expressed a fear that the IHS would be required to 'means-test' to determine financial eligibility for services at some point in the future. The increasing reliance of the IHS upon revenues from Medicare and Medicaid underscored their concerns about means testing. The leaders questioned the validity of the IHS as a "residual' provider of health care and recommended that it be the "primary' provider of health services for Indian people and be funded appropriately. Tribal leaders recommended that Tribes be "treated as States' in determining eligibility for other

federal programs and resources beyond the IHS. It was suggested that HHS resources be combined into 'block grants' and funded directly to tribal governments. Tribal leaders expressed concern about the social and financial impact of Indian families returning from urban areas to live on the reservations. Other regional concerns included the lack of adequate funding for the "Healthy Start" program, overall funding for children health and the need to develop treatment programs for those using methamphetamine. It was recommended that the IHS conduct a national strategic planning process to better respond to the changing environment and that it consider 'regional advocacy" to better focus on the unique health needs in each region.

Crosscutting Issues

much of the discussion on the consultation process and the commitment of HHS to follow-up and respond to tribal issues and recommendations. Lack of funding for all aspects of the IHS was highlighted throughout the meeting, specifically regarding Contract Health Services (CHS), alcohol prevention, adolescent health, elderly care, nursing home care, diabetes, cancer, the Catastrophic Health Emergency Fund (CHEF), emergency medical services, HIV/AIDS, mental health services and appropriate staffing of health professionals. Like other regions, Bismarck participants were concerned about the lack of funding for new and replacement hospitals and clinics. The issue of traditional Indian healing practices and its relationship to the IHS was raised at the Bismarck meeting.

Other issues included: racism or 'anti-Indian sentirnent' surrounding Indian reservations and comrnunities; technical assistance in dealing with States around managed care and other reimbursement issues; amending federal law to make Indian health care an 'entitlement' as opposed to a discretionary program of the government; supporting the reauthorization of the Indian Health Care Improvement Act (PL. 94-437); concern that the current Medicare program does not adequately support costs associated with nursing home care; questions regarding eligibility for IHS services and requests that a final rule be established; the impact that depressed reservation economies have on the health status of Indian families and the need to address these concerns more holistically; the United States Department of Agriculture Commodity Food Program was identified as one of the problems in making a connection between improved health care and addressing the effects of @ p
poverty; the impact of welfare reform on Indian families and their health care was identified; environ,mental issues affecting Indian health status, such as water pollution, bad roads, and lack of transportation services. Finally, Tribes asked that Congress make a long-term commitment to Indian people and fully fund its treaty obligations to provide health services.

Seattle, Washington, January 21, 1999

The Seattle Listening Council included tribal leaders from Alaska, Washington, Oregon, Idaho and Northern California and was moderated by Julia Davis, a member of the Nez Perce Tribal Executive Committee. Approximately 56 individuals participated in this Listening Council. A site visit was made to the Seattle Indian Health Board. Introductory remarks were provided by Dr. Trujillo, followed by opening remarks by Deputy Secretary Thurm. After introductions, each elected tribal official was provided time **to** make a formal statement or present an issue to the federal representatives.

Regional / Local Issues

Some of the issues and recommendations raised at the Seattle meeting which were not raised in other regions included concerns for the increase in inhalant abuse among Indian youth and the need for treatment services for this population. A rec- @ ommendation was made that existing federal law be modified so that individual Tribes can access funds appropriated for Regional Youth Treatment Centers (RYTC) to address substance abuse issues locally. California tribal leaders recommended that at least two RYTC be allowed in that State to cover the vast territory. A recommendation was made to also support the existing RYTC.

Other issues included: the need for technical assistance to access federal tobacco control funding-, increased funds to serve the large number of urban Indians in California; the request that the National Institutes of Health (NIH) and the Centers for Disease Control and Prevention (CDC) assist Tribes in the development of local Institutional Research Boards (IRB) and provide Tribes with the opportunity to approve and review any and all research affecting Tribes; the need to appoint Indian people to the Medicare and Medicaid Advisory Committee through HI-f S and to require that the Health Resources and Services Administration (HRSA) go through a similar consultation process with Tribes; concerns about the Base Closure Act and whether tribal interests were protected and included in this process.

Crosscutting Issues

Like other regions, the Seat-de participants discussed the HHS consultation process and the steps for follow-up to the Listening Councils. The federal obligation to fulfill Indian treaty rights, its trust responsibility to provide health services, and the requirement that Congress appropriate adequate funds to meet this obligation, was a corner- stone of these discussions. Funding is not adequate across the board for IHS, in particular full funding for "mandatory increases," such as medical inflation, payroll increases and population growth should not be taken away from service funds but funded additionally. Increased funding is needed for diabetes, Contract Health Services (CHS), dental care, catastrophic illnesses and accidents, elderly care, adolescent health, for alcohol and substance abuse treatment and prevention and for staffing.

The lack of funding for facilities construction for outpatient clinics and sanitary water/sewer systems was also identified. The "Joint Venture' program

to fund the equipment and staffing of tribally constructed outpatient health clinics was identified as a successfid model and recommended to receive more attention and future funding.

Like the two previous regional Listening Councils, Tribes in Seattle identified the problem of patient travel and geographical access barriers to care and transportation costs as hindering their ability to provide adequate services. Tribal leaders also voiced strong support for the elevation of the Director of the IHS to an Assistant Secretary level. As in other regions, Tribes voiced their support for the reauthorization of the IHCIA and asked for assistance and advocacy from the Health Care Financing Administration (HCFA) in edu- cating States about the unique status of Tribes.
The current Memorandum of Agreement between the IHS and HCFA needs more exposure at the State level and barriers to Medicare/Medicaid reimbursement for Tribes must be addressed. Q-Uestions were raised about the unwillingness of some States to reimburse Tribes retroactively as "Federally Qualified Health Centers' (FQHC), under the IHS/HCFA Memorandum of Agreement. It was recommended that HCFA engage in negotiated rulemaking and meaningful consultation with tribal governments on these and other issues. As in Bismarck, the tribal leaders in Seattle voiced strong support that the IHS should be funded as an entitlement program and not a discretionary program. The issue of 'equity" in the allocation of IHS resources was raised, and a rec- ommendation was made that an actuarial approach be adopted in the allocation of funds.

With regard to welfare reform, Tribes voiced concern that a formal tribal consultation process be initiated for TANP issues. It was recommended that federal support be provided to administer TANF funds for Tribes, just as it is provided for States. Questions were raised about the process and funding allocation methodology under the child support enforcement statute and the need for more attention on this issue. More funding for social service programs are needed in tribal communities. Child welfare funds should go directly to Tribes and not through States. The ceiling on indirect costs rates allowable to tribal Head Start programs is a problem and should be lifted.

Oklahoma City, Oklahoma, March 9, 1999

The Oklahoma City Listening Council included tribal leaders and Indian organizations from Oklahoma, Kansas, Nebraska and Texas. The meeting, which included 104 participants, was facilitated by Ruey Darrow, Chairman of the Fort SiU Apache Tribe in Oklahoma and Wanda Stone, Chairperson for the Kaw Tribe of Oklahoma. Dr. Trujillo provided an overview and expressed HHS's intent to "bring into effect the consultation process' and involvement of Tribes with the numerous agencies and programs of the Department. While the HHS has an Indian-spe- cific agency and program, the IHS and the Administration for Native Americans (ANA), there are many more programs and authorities under the Department that impact tribal commu- nities and should be addressed. Deputy Secretary Thurm made a brief presentation regarding his

intent to listen to the concerns voiced by Tribes and his commitment to provide feedback and follow-up on the major themes that emerge. He also stated that it was his goal to institutionalize this consultation process within HHS, so that it will not be dependent on any one individual but will be an ongoing Departmental process. Dr. Trujillo and Deputy Secretary Thurm made a site visit to the Lawton Indian Hospital and the El Reno Health Center in Oklahoma.

Regional / Local Issues

A recurring regional theme that emerged at the Oklahoma City Listening Council was the issue of "equity" in the distribution the IHS resources and the belief that Oklahoma was not receiving its fair share based upon a per capita allocation formula. While strong support was voiced for overall increases to the IHS budget, the allocation methodology within the IHS was identified as requiring more attention and fairness. Support was voiced for construction funding for replacement of the Lawton Indian Hospital and for increased funding for maintenance and improvement at that facility. Increased funding at all the Oklahoma Area hospitals was recommended.

A question was raised regarding the potential impacts of a planned contracting of the Claremore Hospital under the Indian Self-Determination and Education Assistance Act (RL. 93-638). It was recommended that additional funds be provided to support a needed inpatient alcohol and drug treatment facility in Western Oklahoma. There were conflicting recommendations expressed regarding the two urban demonstration projects funded in Oklahoma City and Tulsa, with participants suggesting that these programs be made permanent under PL. 94-437 and others suggesting that only Tulsa should be designated permanent status. A recommendation was also made to extend coverage under the Federal Tort Claims Act and the Office of Management and Budget (OMB) reimbursement rates for Medicare and Medicaid to these two urban denomination sites.

Crosscutting Issues

Most of the issues discussed at the Oklahoma City Listening Council were of national and crosscutting significance. Increased funding for existing IHS initiatives was a recurring theme. Tribal leaders also recommended that the IHS develop a system whereby any IHS eligible patient can receive service at any IHS funded facility and that facility will be reimbursed by that patient's tribal or IHS provider. More funds are needed for diabetes, Community Health Representatives (CHR), environmental health, emergency medical services, pharmacy services, elderly care, dialysis, health scholarships, alcohol and substance abuse treatment and prevention, public health nursing, community health training, and increased funding for dental services.

Like other regions, the tribal leaders at the Oklahoma City meeting expressed their concern that funding is not adequate for the construction of new and replacement inpatient and outpatient facilities. Recommendations were made to lift the moratorium on contracting under RL. 93-638 and to adequately fund Contract Support Costs and Indirect Costs. Tribes asked for a consultation

process with HCFA to improve third-party billing for Tribes. Reimbursement rates for Tribes and urban programs under FQHC are scheduled to decline to only 70% of costs with no plan to cover that gap. It was recommended that the 'direct billing" for Medicaid and Medicare be approved for all Tribes contracting their own health systems, and not just the demonstration Tribes. Tribes requested help from HHS to get Medicare cover- age for home health care and hospice care for their elderly. Tribes asked that the Secretary of HHS use her authority to waive the budget 'caps' for the IHS when preparing her annual budget request. As in other regions, the problem of access due **to** inadequate transportation services was highlighted.

Other issues included: support for the elevation of the IHS Director to an Assistant Secretary level; lifting the moratorium on defining eligibility regulations for IHS; that the Secretary establish an Indian Advisory Committee to HHS; concern about welfare reform implementation and whether it can work in the face of high unemployment in Indian country; funding cuts to the Child Care Bureau; the need for funding for construction of Head Start facilities; and more access to funding and support from other agencies such as NIH and CDC.

Syracuse, New York, May 21, 1999

The Syracuse Listening Council was a forum for Eastern and Southeastern Tribes located in New York, Maine, Massachusetts, Rhode Island, Connecticut, North Carolina, South Carolina, Mississippi, Alabama, Louisiana, and Florida. Mr. Tim Martin, Executive Director of the United South and Eastern Tribes (USET) moderated the meeting. Dr. Trujillo and Deputy Secretary Thurrn made a site visit **to** the Catmmgus and Allegany Reservations in New York.

Regional / Local lssues

Most of the issues and recommendations expressed by tribal leaders at the meeting held in Syracuse were national in scope, however a few issues were of regional or local concern. The international border between the United States and Canada creates many difficulties for tribal programs serving families with ties to both countries. Spedfically, tribal leaders expressed frustration about the difficulty in making child custody placements or child custody agreements when each parent resides on different sides of the border. They specifically sought HHS assistance in existing the support of the State Department. A concern was raised that the public as well as the State and Federal governments misperceive the availability of "gaming revenue' to meet Tribes' health and human services needs. Many Tribes do not operate gaming enterprises,

and most of those that do operate such facilities do not generate the level of funding necessary to meet the significant needs in tribal communities.

There were concerns about the rise in the number of Al/ANs who smoke, the rise in heart disease due to the lack of adequate prevention initiatives, the need for more radiology and optometry servic- es, and an increase in substance abuse (the Tribes identified the Department ofjustice 'Drug Courts' as an excellent model of integrating health and law enforcement resources to intervene with addicted individuals); the need for more flexibility in HHS programs; and the problem of Indian bur- ial sites being disturbed and vandalized.

Crosscutting Issues

As in the previous listening councils, tribal leaders were particularly concerned about the specific , steps that the HHS would take to document, investigate and respond to each issue and recommendation raised.

Tribes expressed the need for 'aftercare' services for Indian patients coming home from inpatient alcohol and drug treatment. There is a significant amount of air and water pollution in the north- eastern states which adversely impact the health of Indian communities. Wh@e this was expressed as a regional issue, it was a common concern in other areas as well.

Funding for Indian health senices was a recurring theme at the Syracuse meeting. Tribal leaders recommended a structured HCFA consultation process through which issues relating to Medicaid and Medicare reimbursement rates could be addressed. Tribes also requested a standard federal rate for hospital services, similar to the standard Medicare rate, which limits the amount hospitals can charge for services to Medicare patients. Tribes expressed concern that States are not recognizing, cooperating with or serving Indian comrnunities. Participants expressed concern about the allocation of IHS resources and recommended that the "Level of Need Funding" (LNF) formula be reviewed for fairness and improvement. It was also recommended that the overall impact on funding due to contracting under P L. 93-638, Title 111, be reviewed.

The Tribes voiced support for the elevation of the IHS Director to an Assistant Secretary level. Tribes expressed concern about the lack of ade- quate data systems to report and monitor the health status of Indian populations. Services pro- vided with IHS dollars to 'non-eligible' popula- tions should require additional funds. When the federal government recognizes new Tribes, addi- tional funds should be appropriated to support the health needs of that Tribe rather than taking it from the existing IHS budget. Tribal leaders expressed their support for the reauthorization of the IHCIA and recommended that Indian health care be made an 'entitlement,' not a discretionary program.

Other issues included: TANF implementation; the need for more resources for child care services in Indian communities; HHS flexibility with respect to program requirements when dealing with tribal governments; the need **to** provide social services to

families returning from other areas to their home reservations; the protection of tribal languages and tribal cultures; the inadequacy of IHS funding to meet Indian health needs, in particular for diabetes, alcohol and substance abuse, CHS, prevention initiatives, long-term elder care, tobacco control and smoking cessation, cancer and heart disease prevention and treatment, HIV/AIDS, dental care, radiology, optometry, youth education, and construction of tribal health facilities; and the need for scholarship assistance to Indian students interested in health professions.

It was also recommended that in honoring its treaty obligations, including the obligation **to** pro- vide health services, the federal government, in particular the OMB, must consult with Tribes in making decisions that affect tribal communities.

Summary of Crosscutting Issues and Themes that Emerged

In all, tribal leaders and other Indian organization representatives raised 52 distinct crosscutting or national issues and recommendations at the **five** Listening Councils which we have divided into seven categories or themes as follows:

1. Funding and Budget Issues
2. Services and Service Provision
3. Care Providers
4. Facilities, Equipment and Supplies
5. Intergovernmental Relations and Related Issues
6. Infrastructure
7. Data and Research

The majority of individual issues and recommendations raised by tribal leaders (20 out of 52) related to the first category, 'Funding and Budget Issues.' The next most frequently addressed area (14) was 'Intergovernmental Relations and Related Issues.' The category "Services and Service Provision7 included 8 distinct issues. The remaining categories had fewer than 5 distinct issues in each. The following is a brief discussion of each of the seven major themes.

1. Funding and Budget Issues

This category consolidates a wide array of concerns expressed by tribal leaders, such as appropriations for specific IHS programs to reimbursement policies of the Medicaid and Medicare programs. Many of the concerns relate directly
to the level of funds appropriated to the IHS to support health services, transportation, sanitation services, construction, CHRS, and nursing. Other issues and concerns relate to policies within the IHS, such as the distribution and allocation of resources among the Tribes and areas within the IHS system. Still other issues relate to legislative mandates by the Congress, such as the moratorium on contracting under the PL. 93-638 and related funding for contract support costs. Concerns raised about the eligibility for services address both IHS policy and congressional man-- dates. A summary of the funding/budget issues and recommendations is as follows:

Health Services and Transportation

Insufficient funding for health services and transportation services. Establish a line itern for health services. Support appropriation for health services at level of need.

Water and Sewer Systems

Lack of funding for **water** and sewer maintenance and repairs and testing of water systems. Appropriately fund maintenance and improvements.

Construction Financing

Lack of funding to build, expand, replace, and maintain health care facilities. Find innovative financing for Tribes to build health care facilities,

Native Healers

Lack of funding for traditional native healers and practitioners.

Prevention

Lack of funding for prevention activities. Funding is only enough to address primary care.

CHR/CHN

Underfunding of Community Health Representatives and Clinical Health Nurse Programs.

CHS

Underfunding of Contract Health Services. Earmark funds for CHS and increase CHS funds.

Targeted Health Needs

Underfunding of environmental health; Emergency Medical Services (EMS); long-term elderly care; aftercare services; alcohol/substance abuse programs; diabetes programs; prevention, **intervention** and health education programs and outreach efforts. Appropriate line items for EMS funds, tribal EMS programs, elder care, alcohol prevention and treatment and commit to long-term diabetes initiative.

Contract Support Costs

Underfunding of administrative and indirect funds for compacting and contracting under P.L. 93-638. Appropriate sufficient funds for administrative costs to Tribes.

Equity within IHS

Insufficient appropriations to keep pace with inflation, growth of Indian population or level of needs. Inequitable funding across Tribes and areas on per capita allocation. Inadequate allocation formula. Adjust the IHCIA that authorizes the IHS improvement fund for equity funding.

PL. 93-638 Contracting

Opposition to moratorium on PL. 93-638 funding, payment of Contract Support Costs or reallocation of CSC on a pro rata method.

Equity Compared to Other Populations

Inequitable funding for Indian population as corn- pared to other U.S. populations. Fully involve Tribes in the budget process and budget discussions and legislation.

Third Party Revenues

Inappropriate consideration of third-party collections in budget decisions.

Managed Care

Impact of managed care on Tribes and tribal **reimbursements.**

Demonstration Projects

Provide more funds for demonstration grants on important health issues. Difficult to implement new approaches to care without adequate or accessible funding.

Service Eligibility and Payment

Services provided to other Tribes' members limits or reduces funds to Tribes providing the service.

HCFA, Medicaid and Managed Care

Assist Tribes in working with HCFA in the area of managed care.

IHS Capitated Restrictions

Support provision that authorizes IHS to enter into capitation agreements for managed care.

Medicare

Assist freestanding health centers in billing Medicare for outpatient services.

Diabetes Fund Allocation

Change the allocation methodology for diabetes funding.

2. Services and Service Provision

The next major crosscutting theme, which emerged during the five Listening Councils, incor- porates issues related to the provision of services. These issues can be divided into those that require additional appropriations under existing authority of the IHS, those that require a change in federal law and those that require new initiatives within existing budgets and authorities.

Traditional Healers

Recognize and support the need and use of traditional American Indian healers. There should be a policy that recognizes the use of traditional American Indian healers and practitioners in mental health.

Expand scope of services provided

Need to improve and provide access to: specialty and inpatient care; behavioral health services, including alcohol/substance abuse programs that include services for children, adolescents and women; diabetes programs; prevention and health education; pre-hospital emergency medical servic- es; hospice and physical therapy programs; long term elderly care; and in home or special trans- portation for disabled people. IHS should be given authority to license long-term health care units on reservations. Support in obtaining ambu- lances to provide 24-hour coverage.

Dialysis units

Need for dialysis units and **to** increase the size of existing units.

Access to alternatives

Lack of access **to** "charity care'

Cancer Screening

Need to increase focus on cancer screening for men.

Holistic Services

Need **to** provide holistic services for families, including mental health services.

Medicaid Barriers

Parents who **are not** legally married **are** unable **to enroll their** families in Medicaid.

Medicare and Medicaid Outreach

Outreach needed **to** develop brochure describing Medicare benefits and provide information on Medicare and Medicaid in plain language.

3. Care Providers

The third crosscutting theme that emerged from the Listening Councils involved improvements or increasing the numbers and types of care providers available to Indian communities. The IHS has available to it programs under Title I of RL. 94- 437 to recruit, train, place and retain qualified health professionals. Despite this resource, Tribes voiced concern about the lack of providers in certain fields and the difficulty in retaining providers.

More Providers of Care Needed

Too few health care providers result in high patient care load. IHS must use existing options **to** encourage careers in IHS and enhance training of American Indians Alaska Natives (Al/AN) in health professions.

Provider Licensure

Some providers lack appropriate credentials. Assist with licensing of dentists and doctors who are licensed in another State. Assist Tribes to access training and continuing education for physicians and staff.

4. **Facilities, Equipment and Supplies**

Numerous issues and recommendations regarding facilities, equipment and supplies were raised by tribal leaders at all **five** Listening Councils. Many Tribes expressed support for their local inpatient or outpatient facility to be replaced or newly constructed. Others expressed concern about the lack of funding for basic upkeep of existing facilities.

Lack of Facilities

Lack of facilities for health services, chemical dependency programs, renal dialysis units/clinics, nursing homes, and emergency rooms. Assist Tribes to find alternate means for constructing needed facilities and upgrade emergency rooms.

Quality of Facilities

Inability of facilities to meet Joint Commission for the Accreditation of Health Care Organizations (JCAHCO) standards means tribal facilities can- not compete with non-tribal facilities for patients.

Facility Construction / Replacement Process

The existing IHS process **to** identify, prioritize and justify new construction and replacement is time consuming and not working. Facility con- struction issues affect the number of medical staff, equipment, supplies and auxiliary providers. Delay in new construction also delays funding **to** bridge the gap between existing services and required services.

Equipment

Need for disaster preparedness and disaster response equipment.

5. Intergovernmental Relations and Related Issues:

One theme focused upon at all of the **five** Listening Councils was the area of tribal consulta- tion, follow-up, and intergovernmental relations. The legal and historic Government-to- Government relationship is the foundation for these tribal consultation meetings and must not be overlooked. Beyond the process of holding meet- ings, tribal leaders want assurance that specific follow-up would be undertaken by HHS to address each of the issues raised and institutionalize the consultation process. There were fourteen specific issue areas, and recommendations, identified under this major theme.

Partnerships

Explore new and creative approaches or partner- ships for efficient delivery of services for Tribes. Encourage collaboration between State and Tribal governments. Assist in helping private businesses become partners with Tribes.

Input and Advocacy

Establish a HHS Advisory body that includes tribal leaders. Develop a website for Al/AN to make their needs known or respond to issues that affect them. Assure that all Tribes are Internet capable. Establish an "Indian Desk7 in all HHS agencies to allow better access to resources and technical assistance.

Consultation Follow-Up

Concern about another consultation process without clear follow up. Establish a plan and timeline for achieving results to the Listening Council meetings.

State Relations

States do not have adequate outreach services in rural areas of the States.

Direct Federal Funding

Tribes need to have access to more thin just demonstration projects. HHS should implement a pilot program for direct federal funding to Tribes from agencies rather than going through the States. Look beyond the IHS for funding to identify other sources that should be made available to Tribes. Initiate and develop tribal specific grants.

Welfare Reform

Need to address the impact of welfare reform on Al/AN.

Budget Formulation

Provide Tribes the opportunity to impact the long term planning for the budget. The budget consultation discussion center on forgone conclusions, loss of opportunity to influence the outcome. HHS should allow for joint funding of projects to fund services more comprehensively.

Remove Ca
,Ps on Indirect Rates

Tribes are seeking to raise the cap on funding of indirect costs allowed for Head Start programs which they administer.

Technical Assistance and Information

Assist Tribes to maneuver through the federal system by providing contacts in each agency for technical assistance and information dissemination. Too many obstacles and red tape.

International Border Issues.

The international border issues, such as the U.S. and Canada, create many difficulties for tribal programs servicing Indian people with ties to both countries. For example, Tribes are not able to pro- vide services for children of divorced parents when one parent resides in the U.S. and the other resides outside the U.S

Consultation Overload

The agency-level consultation process places a burden on Tribes. There should be one workable consultation process.

HHS Key Staff

Fill the permanent positions in the **Office** of the Secretary, Office of Intergovernmental Affairs.

LHS Director Ekvation

Elevate the position of IHS Director **to** Assistant Secretary.

6. Infrastructure

The deterioration of sanitary water and sewer infrastructure systems was identified at several of the Listening Councils. Tribes have requested assistance to repair these systems and adequately fund operations and maintenance. Training should be provided to Tribes to make repairs as needed. joint efforts are needed to address the impact of contaminated land and water from waste, weed sprays, fertilizers and other pollutants.

7. **Data and** Research

Two issues were raised in regard to data and research. Those included making community spe. cific health care data more accessible to tribal communities and establishing a national database of companies that can provide assistance to tribal programs, such as pharmaceutical companies.

Part II-HHS Responses to the Issues and Concerns of Tribal Leaders

Actions taken by HHS since Listening Councils

Verbatim transcripts from each of the five Listening Councils were made available to tribal leaders for the meeting in which they participated. To meet our commitment to tribal leaders to address the issues raised at the Listening Councils, the 52 crosscutting/national issues were forwarded to the appropriate HHS agency(ies) for response. A template was developed to facilitate agency responses to the 52 issues. The template requested the following seven items for each issue:

1. Public law(s) or authorization, if any, related to this issue/issue area.
2. Proposed agency actions to address this issue/issue area.
3. Agency activities **to** date on this issue/issue area.
4. Appropriation information related to the issue/issue area (FYOO, FY01)
5. Obstacles **to** addressing issue/issue area.
6. Strategies **to** overcome obstacles.
7. Agency contact on this issue/issue area.

A matrix which contains HHS agency responses to these specific items will be made available to tribal leaders. Abbreviated responses from HHS agencies have been incorporated into this Summary Report. A national forum for tribal consultation will be held to review specific agency responses and to provide an opportunity for additional dialogue.

Summary of responses from HHS agencies by major themes

This section of the Summary Report condenses Agency responses within the seven major themes that emerged **at** the **five** regional Listening Councils.

1. Funding and Budget Issues

There were twenty individual issues raised under this category which fall within one of five sub-categories: Appropriation Levels; IHS Allocation Policies; Congressional Mandates; Administration Policies; and Patient Generated Revenues.

Appropriation Levels

Recommendations for increased funding for specific types of services such as transportation, CHRS, water and sewer systems, facility construction, traditional healers, prevention, and CHS

received specific responses from the IHS. The Substance Abuse and Mental Health Services Administration (SAMHSA), the Health Resources and Services Administration (HRSA), the Health Care Financing Administration (HCFA), the Administration on Aging (AOA), the Agency for Healthcare Research and Quality (AHRQ, the Administration for Children and Families (ACF), and the Centers for Disease Control and Prevention (CDC) also commented regarding the appropriations process and its impact on each agency's ability to meet certain health care needs.

IHS formally includes tribal leaders and Indian organizations in the annual budget formulation process, whereby Indian leaders can identify target funding to meet priority health care needs. It is a comprehensive process in which tribal leadership works to reach consensus on funding priorities. The authority of the Snyder Act (25 U.S.C. 13) provides basic authority for most of the health care services provided by the federal government and those services identified by tribal leaders for @ increased funding. In meeting the priority needs identified by tribal leaders the primary limitation is the level of funds appropriated by Congress each year, the budget lines associated with the appropriation, and the fact that the IHS is not an entitlement program. The IHS is a discretionary pro- gram that depends on an annual appropriation.

Other federal agencies, such as AOA, HRSA, SAMHSA and ACF provide funding for certain types of health care services. Their funding authority is not as broad as that allowed IHS under the Snyder Act, but generally tied to a specific service or target population. These agencies are also subject to annual appropriations.

HCFA responded to these issues as well, providing information about the Medicaid and Medicare programs and the services that are eligible for coverage under each. Unlike discretionary programs, the Medicare and Medicaid programs are entitlement programs and funded differently. HCFA does not submit an annual appropriations request for Medicare benefits, but the benefits are paid on the basis of a permanent, indefinite appropriation authority. Medicaid is a 'Federal-State" matching program that under current law makes grants only to States, the District of Columbia, and territories. Changes to federal law would, be required to allow direct grants to Tribes.

IHSAllocation Policies

There were numerous issues raised regarding the way in which funds appropriated to the IHS are allocated among the twelve IHS areas and the many individual Tribes and communities. Issues were raised regarding the "equity" of the current distribution methodology for base funding as well as for special funding, such as the diabetes initia- tive. Several ongoing efforts by the IHS are target- ing the disparity in health resources that exists across Indian country. The extensive consultation with Tribes in the budget formulation process allows Tribes to target funding to meet priority health care needs. A study is currently underway to examine health funding parity for Indian people compared to the Federal Employees Health Benefit Plan. This study, known as the Level of

Need Funded (LNF) study, uses actuarial methods to estimate the costs of a mainstream benefits plan for Indians. Consultation with Indian Tribes is still ongoing about the possibility of using LNF study results in new resource allocation formulas to address the inequities within Indian country. Regarding diabetes funding, the IHS established its allocation policy for these funds in consultation with tribal leadership and continues to meet with a Tribal Diabetes Advisory Committee regarding allocation and other concerns.

Congressional Mandates

Several issues were raised that relate specifically to actions taken by Congress that affect the ability of Tribes and IHS to provide health services to Indian communities. Those issues include the "Moratorium' that Congress placed on further contracting of IHS services under the RL. 93-638; inadequate funding for CSC associated with administering P.L. 93-638 contracts; use of Medicare and Medicaid revenues to offset the IHS budget; restrictions preventing the IHS from entering a risk-based capitated plan; and the moratorium on **final** rules for IHS eligibility. Each of these issues had a significant impact on tribal and Indian communities. The IHS responded to these issues, stating its support and advocacy for full funding of CSC. The IHS recently adopted a revised policy on CSC after undergoing an extensive tribal consultation process to ensure equitable distribution of any funding made available for CSC. In addressing the inequity in CSC funding, the new IHS policy abandons the historic approach and the maintenance of a "queue list" in favor of a distribution methodology whereby Tribes received additional CSC funding proportionate to their overall CSC needs. The IHS continues to support Tribe/Tribal organization contracting under RL. 93-638 and opposes any moratorium. The FY 2000 Consolidated Appropriation Act was signed into law in November 1999, and lifted the previous moratorium on contracting.

Regarding the use of anticipated Medicare/Medicaid revenues to offset the IHS budget, both IHS and HCFA cited the IHCIA (P L. 94-437, Title 11, Sec. 207(b)), which explicitly prohibits the IHS from using the amounts generated to offset the IHS budget. IHS stated that it has done significant work to increase third party collections in recent years and does not believe that these increases have made appropriations requested or provided for IHS smaller than they would otherwise have been. IHS will continue to work with HHS, OMB and the Appropriation Committees in making the most compelling possible case for increased appropriations.

Regarding the other congressional mandates, such as the moratorium on **final** eligibility rules and restrictions on IHS participation in capitated managed care plans, the IHS responded by citing the specific mandate in Federal law. Lifting the **final** rule on eligibility will require new law, which is proposed in current drafts reauthorizing the - Indian Health Care Improvement Act. Similarly, for the IHS **to** participate in a capitated managed care plan, federal law would be required **to** lift restrictions of the Anti-Deficiency Act.

Administration Policies

The most significant funding and budgeting issues raised regarding overall Administration policies is the inequity of funding for Indian health in comparison to other populations and other federally funded health care programs. Tribal leaders are seeking fairness and proportionality in the allocation of all HHS resources to Indian populations. The following HHS agencies responded to this issue: IHS, AOA, HCFA, AHRQ., CDC, HRSA, IGA, and SAMHSA.ME IHS has developed a formal consultation process to involve tribal leaders in its budget formulation. The AOA is planning a Tribal Listening Session for August 8, 2000 to provide tribal leaders the opportunity to express their concerns, comments and ideas. CDC reports that it will conduct an annual Al/AN Budget Planning and Priorities Meeting and implement
its tribal consultation policy. CDC held its **first** budget consultation in March 2000 and provided a list of Requests for Proposals (RFP) that are currently available to Tribes. HRSA plans to hold a budget meeting in 2001 in preparation for FY
2003 budget formulation. IGA and ASMB organize an annual budget consultation for HHS. HCFA participated in the April 10, 2000 budget meeting with Tribes and is reviewing tribal budget recommendations. SAMHSA wiU continue **to** provide technical assistance workshops **to** assist potential applicants for discretionary grants, which Tribes are eligible to attend.

Patient Generated Revenues

There were many issues raised and recommendations made regarding patient generated revenues, primarily regarding Medicare, Medicaid, and man- aged care systems. The Tribes, tribal organizations and urban health providers are becoming more dependent upon their ability to generate revenue through patient visits by biffing third-party payers. As States undergo efforts to control health care costs, primarily through the use of managed care organizations to provide services to Medicaid patients, the IHS, Tribes and urban providers are affected. Concerns were expressed about decreased Medicaid reimbursements resulting from States implementation of managed care programs. HCFA has been working with States and Tribes to address this issue and to explore alternative payment methodologies for IHS/Tribal/Urban providers. Both Arizona and Oklahoma have already incorporated alternative payment methods into their Medicaid payment systems. As viable alternative payment approaches are identified, HCFA reports that it will share them with Tribes and States. HCFA asserts that it will work with States and the Tribes through consultation and provision of technical assistance to increase I/T/U access to managed care contracts in an effort to mitigate any negative impact on the provision of health care to Al/ANs.

2. Services and Service Provision

With respect to this category, the tribal leaders generally are seeking a broader scope of services for Indian people, access to traditional and holistic interventions, and better access to alternative coverage for care. The responses from HHS agencies will be discussed in these three general sub-categories.

Traditional and Holistic Care

Tribal leaders and representatives from Indian organizations made several recommendations regarding improved access to and funding of traditional American Indian healing, and access to

'holistic" care for Indian families. The agencies responding to these issues included IHS, HRSA, ACF, SAMHSA, and AHRQ. While the Snyder Act provides broad authority for IHS to provide a wide range of health care services, the decision about the extent to which traditional American Indian healing is incorporated into health services is a local one. IHS reports that after lengthy tribal consultation on this issue, there is no consensus among Tribes regarding the role of the federal government involving traditional healing. The AHRQ funds a small number of studies on alter- native and complementary medicine, some of which are co-funded by the National Center for Complementary and Alternative Medicine at NIH. SAMHSA is currently administering a three-year discretionary grant program, "the Circles of Care," targeting tribal communities to improve the service system for children and youth with serious emotional disturbances. One of the program's objectives is to integrate traditional healing methods indigenous to the communities. Further, tribal grantees in the program are using a holistic approach to integrate services and make them family-based and culturally competent. The Commissioner for the Administration for Native Americans (ANA) has established a traditional Elders' Circle that has been engaged in discussions concerning traditional healers/practices. Each member of the ANA Elders' Circle is a traditional healer. HRSA reports on the Navajo Integrated HIV Service Delivery Model Program which will conduct a once a year comprehensive, HIV planning initiative that will define and evaluate the integration of HIV services into existing services currently provided by the IHS and the Bureau of Indian Affairs (BIA).

Scope of Service

'The **five** Listening Councils generated a long list of services that require additional support or an increase in services or development. These included access to specialty care, inpatient care, behavioral health, alcohol/substance abuse programs, health education, long-term care, home- and community-based care, dialysis units, cancer screening for men, 24-hour emergency coverage and other services. Tribes urged IHS to help license providers and facilities in this regard. The major obstacle to addressing the need for an increased scope in services is the lack of adequate appropriations. These issues are addressed in the Funding and Budget section of this report. The authority for the IHS to meet these added services exists largely under the Snyder Act. HCFA funds dialysis units, but providers must make requests to 1-fCFA **or** HCFA contractors. The IHS senior clinician in renal disease has been analyzing the data sets of both IHS and HCFA regarding the issues of treatment of end stage renal dialysis (ESRD) and visited many communities **to** review the issues locally. He will provide his analysis to tribal leadership considering expanding dialysis activities or other approaches **to** treatment of ESRD. HRSA's activities and partnership with IHS provides sup- port for American Indian emergency medical services programs throughout the U.S. Support is pro- vided for expert medical direction, training, and other services to more than 100 tribal EMS pro- grams.

Access to Coverage

Issues were raised regarding access to "charity care' programs for Indian populations, barriers to Medicaid and increased outreach for Medicare and

Medicaid enrollment. These issues were referred to IHS, and HCFA for response. With regard to 'charity care,' HCFA responded that a Medicare payment adjustment is provided for hospitals that serve a disproportionate share of low-income patients. The factors considered in determining whether a hospital qualifies-for a payment adjust- ment include the number of beds, the number of patient days, and the hospital's location. IHS or tribal hospitals that are Medicaid providers may quaw for additional payments above the State Plan rate as Disproportionate Share Hospital Payments (DSH) facilities pursuant to Section 1923 of the Act. HCFA will communicate to States that DSH payments are.available for IHS and tribal hospitals.

Regarding access to Medicaid coverage, HCFA regulations (42 CFR 435.930) require States to provide Medicaid coverage to all persons who have not been properly determined to be "ineligible" for Medicaid. States must affirmatively explore all categories of eligibility before it acts to terminate Medicaid coverage. HCFA has awarded contracts to provide information to Al/ANs about **its** major programs, including projects with Tribes to develop outreach materials regarding Medicare + Choice and related programs. In addition, HCFA has funded a larger initiative that produced outreach materials for elderly and disabled Al/ANs who may be eligible for Medicare and Medicaid.

3. Care Providers

There were two issues raised regarding care providers. The first dealt with the need for more providers to provide needed care; and the second dealt with the need for IHS to assist in Ecensure of health providers from other States assigned to tribal health facilities. HRSA, IHS, and SAMH- SA addressed these issues. With regard to the need for more care providers, IHS points to the PL. 94-437 and its following programs: the IHS Scholarship Program (sections 103 and 104), the Loan Repayment Program (section 108), grants to public and nonprofit health and educational entities to provide training (section 102), recruitment activities (section 112), support for nursing schools (section 118), professional scholarship programs (section 120), and section 217, which provides grants to three colleges and universities for psychology recruitment. The IHS continues to pursue salaries competitive with the private sector to recruit and retain health professionals. SAMHSA provided information about the Office of Minority Health Washington Internships for Native Students program which supports summer intern- ship placements at Tribal Colleges and Universities to train Al/AN students in substance abuse and behavioral health fields. HRSA administers grant programs in the areas of nursing, Allied Health, medicine, dentistry, psychology, and recruitment. With regard to licensure, the IHS responded that it advocates for licensure of all health care providers. Licensure is between the State of jurisdiction, the employing Tribe or Tribal organization, and the individual provider.

4. Facilities, Equipment and Supplies

Four distinct issues came within this category. The **first** issue was the general lack of health care facilities, including clinics, nursing homes, chemical dependency units, renal dialysis units and emergency rooms. Another issue addressed the ability of IHS and tribal facilities **to** meet joint Commission on Accreditation of Health Care Organizations (JCAHCO) standards. Tle third

issue concerned dissatisfaction with the current 11-f S facility construction priority system and the need to examine alternative financing options. The final issue in this category addressed the need for disaster preparedness equipment.

The agencies that responded to these concerns include IHS, HCFA, HRSA, AOA, and SAMH- SA. SAMHSA reported that although it is authorized to fund services for treatment, these funds may not be used for construction of facilities for such programs, although rental and other facility overhead costs may be reimbursable expenses. Regarding alternative financing options, the IHS referenced a roundtable held to address this issue. A document, 'Report of Roundtable Discussion and Analysis of Future Options for Indian Health Care Facility Funding," was disseminated to all Tribes. Utilizing Medicare and Medicaid revenues, the IHS and Tribes are addressing renovation and expansion projects including upgrade of emergency rooms and other facilities. As replacement projects are being processed in the IHS Health Facilities Construction Priority System, upgraded emergency rooms are being considered.

HCFA responded that the accreditation requirements are described in 42 CFR 488.4 to 488.11 for accrediting **organizations,** such as JCAHCO. The Survey and Certification Group in HCFA:s Center for Medicaid and State Operations proposes a two-tiered approach to the issue of how tribally-owned facilities that lack sufficient capital could become accredited. HCFA proposes to ask JCAHCO **to** allow the accreditation fees for tribally owned facilities **to** be waived or offered at a reduced rate, or at least be included under the same rate setting as the IHS.

Since 1980, IHS has supported postgraduate training in institutional environmental health to ensure that a cadre of highly trained specialists to enable IHS and tribal health care facilities will meet all applicable regulatory guidelines and standards. Currently seven of the IHS areas have fiffl time Institutional Environmental Health Specialists on staff to address JCAHCO and other regulatory issues. HCFA is establishing a work- group to determine possible changes in surveying tribal facilities.

Regarding the dissatisfaction with the IHS Health Facilities Construction Priority System Methodology, the IHS responded that extensive consultation regarding the reauthorization of the RL. 94-437 has occurred. IHS anticipates that further tribal consultation will lead to beneficial changes to this system.

The OPHS responded to the issue of disaster preparedness equipment. During Presidential declared disasters or major emergencies, health and medical response assets, with appropriate medical equipment, is furnished through Emergency Support Function #8 (Health and Medical Services) of the Federal Response Plan, by activation and use of the National Disaster Medical System. The IHS seeks funds to provide one time funding to Tribes and Tribal organizations to purchase emergency response equipment. Since 1990, approximately $2 million has been provided to Tribes and tribal organizations to fund injury prevention projects, and to purchase EMS equipment.

S. Intergovernmental Relations and Related Issues

With respect to intergovernmental relations, the Tribes' issues can be divided into three subcategories: structure and process; new initiatives; and changes in law.

Structure and Process

It was recommended that the HHS establish an advisory body that includes tribal leaders and establishes 'Indian Desks" at all the HHS agencies to provide better access to programs and enhance communication. Tribes also wanted to know the specific actions HHS planned to undertake to document, investigate, and respond to each of the issues raised during the Listening Councils, as well as at future tribal consultations. Some participants voiced concern about "consultation overload," and suggested that HHS employ one system or process for providing input. It was recommended that 'key staff" be identified in each agency of HHS and the Office of Intergovernmental Affairs in the Office of the Secretary (IGA) coordinate all -tribal issues. HHS will examine the proposal of establishing a departmental advisory body that includes tribal leaders. Another possible approach to consider is to expand the HHS Inter-Agency Tribal Consultation Workgroup (which is co-chaired by the Directors of the IHS and the IGA) to include tribal representatives.

IGA, which is the HHS liaison to state, local, and tribal governments, is the lead office for tribal consultation. IGA, along with the Office of the Assistant Secretary for Management and Budget, annually convenes a meeting of tribal leaders and Indian organization representatives **to** discuss with HHS leadership tribal appropriation needs and priorities for the following budget cycles. AU HHS agencies responded to the budget consultation issue by underscoring their intent to either continue or to initiate an annual tribal budget consultation process. In addition, all HHS agencies have formulated consultation plans which are being reviewed by the Tribes; most of the agencies have scheduled tribal consultation sessions to formalize this process.

New Initiatives

Tribal leaders suggested new or expanded initiatives beyond the Department and involving other entities, such as HHS/tribal partnerships and other means of collaboration between the Tribes, the States, the private sector and HHS. Interdepartmental coordination will be needed to assist Tribes in addressing issues related to intemational borders, such as drug trafficking and child custody issues. IHS responded that a sub-group of the HHS Interagency Tribal Consultation Workgroup could be charged to meet with tribal leaders and/or their representatives to discuss the issue of partnering with private entities, and to can upon State government officials to explore enhanced collaboration.

ACF identified numerous situations and programs involving partnership with Indian communities and States, in particular related to welfare reform, TANF and child support enforcement. The Office of Child Support Enforcement (OCSE) will be providing direct federal funding to Al/AN under Section 455(f) of the Social Security Act to operate their own Tribal Child Support Enforcement Act upon publication of a final rule.

HCFA identified numerous instances of collaboration between HCFA, Tribes and the States and voiced its commitment to continue working to

develop these partnerships to improve the delivery of services to Al/AN beneficiaries under Medicare, Medicaid and SCHIP.

CDC is proposing to engage the Council of State and Territorial Epidemiologists (CSTE) in the planning and development of surveillance systems for Al/AN communities, including urban Indian populations, and to encourage tribal government participation in the CSTE. IGA, along with all HHS agencies, will work with the national intergovernmental organizations, such as the National Conference of State Legislatures, the National Governors Association, National Association of Counties, and the U.S. Conference of Mayors to formulate tribal/State partnerships and opportunities for collaboration.

HRSA's Healthy Start initiative has provided approximately five million dollars to three tribal governments.

Cbanges in the Law

Several of the recommendations made during the Listening Councils involving intergovernmental relations would require new legislation or changes to existing law. One of the most frequently mentioned change, is the elevation of the IHS Director position to an Assistant Secretary. There have been several bills introduced in the Congress to achieve this change. The Secretary of HHS supports the elevation.

Tribes have also asked that the cap on indirect rates for Head Start be lifted and Tribes be allowed to charge a more realistic rate. ACF responded that the law sets limits on costs of development and administration of Head Start and Early Head Start programs. An administrative waiver is available to exceed the 15% threshold only for a specific time period not to exceed 12 months.

6. Infrastructure

Tribal leaders expressed concern about the deterioration of water and sewer infrastructures in Indian communities. Assistance is requested to repair and replace these systems, including adequate funding for ongoing maintenance and improvement. Training is recommended for tribal communities to conduct their own repairs of these systems rather than depend upon other resources. A joint effort to address the impact of contaminated lands and water from waste, chemical sprays and fertilizers is recommended. The IHS was the only agency to respond to this issue. The IHS, under the authority of the Snyder Act, the IHCIA, The Indian Sanitation Facilities Act, and the Indian Self-Determination and Education Assistance Act provides technical assistance to Tribes on environmental health issues and authorizes Tribes to operate certain environmental health programs. The IHS provides funds to upgrade service to existing Indian homes. Projects to upgrade existing community facilities are funded based on each IHS Area's priority system. The projects are scored on the priority system based on health risk, capital cost, deficiency level, and tribal priority. The IHS plans to upgrade services to 9,300 previously served homes in FY 2000 and 9,660 previously served homes in FY 2001. The IHS budget includes $1,000,000 annually for training personnel from tribal operation and maintenance organizations. The IHS will continue to update the sanitation facilities priority system annually and consult with Tribes on their sanitation facilities needs and priorities.

Concerns regarding contaminated lands and water in Indian communities have also been referred to the Environmental Protection Agency (EPA). Additional follow-up may be needed on issues, such as this one, which require the coordination of other departments.

7. **Data and** Research

Data systems currently available to IHS and tribal health systems should do more than simply gener- ate biffing or patient encounter information. Tribal leaders are interested in user-friendly data systems that can provide community-specific health care data and track health status of the patient popula- tion. The utility of the data systems for local plan- ning and priority setting should be assessed and corrected, if needed. In addition to local data sys- tems, the tribal leaders asked that the Federal gov- emment assist in establishing a national database of pharmaceutical and other companies that pro- vide assistance to tribal health efforts.

AU HHS agencies were asked to respond to the issue of local, community-specific data systems. The IHS response included background on section 602 of P.L. 94-437 which establishes an 'Automated Management Information System" to be established by IHS. This system has evolved into today's "IHS Resource and Patient Management System" (RPMS) that collects both clinical and administrative data. Data is generated at the local level and forwarded to the Area, which in turn sends it to the IHS National Data Repository in Albuquerque where it is aggregated for national purposes. This aggregated data is used primarily for statistical analysis and reporting **to** Congress. IHS reports that the RPMS already can provide local data requested by Tribes, except for a possible lack in staffing to extract data or insuffi- cient training at the local levels. Tribes may not be aware of the reports that can be generated locally.

The Division of Information Resources (DIR) Information Technology Support Center in Albuquerque has provided a series of RPMS train- ing sessions and a national 1-felp Desk for local customers. The IHS also makes information avail- able through the National Data Repository, the Internet, and Epidemiology Centers (Epi). Several of the four Epi Centers have developed innovative strategies to monitor the health status of Tribes and use sophisticated record linkage computer software to correct existing State data sets for racial misclassification. These Epi Centers provide immediate data feedback for self-governed tribal health programs to plan and decide the most effi- cient and effective health care services for their people.

The AOA, through the National Resource Center on American Indian Elders at the University of North Dakota, has developed a computerized needs assessment tool for Tribes to use at their dis- cretion. HCFA responded that the IHS and HCFA have formed a steering committee to address key issues of mutual concern, and is work- ing to establish a data subcommittee to address these issues.

The CDC is working with the IHS to assist tribal governments in developing health data systems that have practical public health applications, such as improved disease surveillance. Pursuant to mak- ing community specific data available, CDC's National Center for Health Statistics (NCHS) has proposed two new surveys: (1) Defined Population

Health and Nutrition Examination Survey (DP- HANES) to provide flexible and timely access to high quality examination and laboratory data for a range of defined populations that cannot be addressed using the standard NHANES frame- work- Most of the sub-populations suited to this system are not sufficiently large and/or sufficiently geographically dispersed to allow efficient data collection using a national sampling frame; (2) State and Local Area Integrated Telephone Survey (SLAITS) to track and monitor questions already existing on NCHS National Health Interview Survey (NHIS), which assesses health status, health insurance, access to care, and health risk factors and' behaviors. CDC also periodically pub- lishes Mortality and Morbidity Weekly Report articles addressing public health issues of impor- tance to Al/AN communities.

HRSA responded that the Office of Minority Health/Office of the Secretary is currently finalizing the Joint Report of the HHS Data Council Working Group on Racial and Ethnic Data and the Data Work Group of the HHS Initiative to eliminate Racial and Ethnic Disparities in Health. IGA will continue to work through the Inter- Agency Tribal Consultation Workgroup to institutionalize the Department's Consultation Policy and address issues such as this. SAMHSA report- ed that Centers for Substance Abuse Prevention (CSA-P) is funding a feasibility study to develop local infrastructure necessary to collect data in Al/AN communities. This data was collected in two communities and will give Tribes a more accurate snapshot of the incidence and prevalence of substance abuse-related violence, especially domestic violence. CSAP is also engaged in the task of developing culturally appropriate measures for substance abuse prevention problems and **efficacy** in their unique prevention programs, through the 'Cultural Core Measures Initiative.'

Finally, AHRQ_responded that it has discussed incorporating IHS data into the Health Cost and Utilization Project (HCUP), a Federal-State- Industry partnership to build a standardized, multi-State, longitudinal data system. Presently, HCUP includes inpatient data and is managed by AHRQ. AHRQ_has also discussed doing an over- sampling of Indians in the Medical Expenditure Panel Survey (MEPS) with the IHS in order to be able to produce data for Al/AN. MEPS is a nationally representative survey of health care use, expenditures, sources of payment, and insurance coverage for the U.S. civilian non-institutionalized population, as well as a national survey of nursing homes and their residents. MEPS is co-sponsored by the AHRQ_and the NCHS. Oversarnpling would produce national, not community-specific data, and would be very costly.

With regard to the request by tribal leaders to develop a national database of pharmaceutical and other companies that provide assistance to Tribes, the IHS responded that a national database of patient assistance for prescription drugs has been established by the Pharmaceutical Research and Manufacturers of America. A complete directory of pharmaceutical companies offering these services can be found on the Internet at http://www.phrma.org/patients. HCFA has provided similar lists to the IHS and will furnish source lists of pharmaceutical companies having drug assistance programs.

National Tribal Consultation Forum

Part III - Attachments

Participants at Regional Listening Councils

Summary of Region Specific and Cross Cutting Issues and Recommendations

Acronyms

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National Tribal Consultation Forum

Summary of Region Specific and Cross Cutting Issues and Recommendations

Scottsdale, Arizona

Issue or Recommendation	Raised by One Participant	Raised by Several Participants	Crosscutting Issue
Importance of Continued Meaningful Consultation		**	***
Increased Funding for IHS		**	***
Inequity of IHS Funding, IHS Manipulation of Funding	*		***
Need for New, Replacement Facilities		**	***
Increase Funding for CHS		**	***
Decreased MediCal Reimbursement, Who Funds the Gap?		**	
Inequitable Allocation of Diabetes Funds Given Rates		**	
Hospital/Clinic Construction Funding for California Tribes	*		
Major Impact of Alcohol/Substance Abuse and Aftercare		**	***
Fund Contract Support Costs (CSC)		**	***
Elderly Care		**	***
Adolescent/Youth Healthcare		**	***
Medicaid/Medicare Access, Advocacy and Assistance		**	***
Disabilities and In-Home Care	*		
Replace the Phoenix Indian Medical Center	*		
Fulfill the Federal Trust Responsibility		**	***
Restructure the IHS to put Dollars in the Field	*		
Partnership with the Private Sector	*		***
State Managed Care Coordination		**	***
Funding for Water/Sewage Systems		**	***
Prevent Motor Vehicle Accidents/Deaths	*		***
Replace Fort Defiance Hospital	*		
Eliminate Moratorium on 638 Contracting and CSC	*		***
Need for Follow-Up to Consultation/Listening Process		**	***
Uranium Mining Exposure	*		
Make Self-Governance Permanent	*		***
Renal Dialysis	*		***
Domestic Violence	*		
State Coordination and Partnership	*		***
Emergency Medical Services			***
DHHS Grants for Tribes, Longer Terms	*		
Increase Pharmacy Services	*		***
Provide Phoenix Area Budget Information	*		
Oppose Pro Rate Distribution of CSC Funds	*		
Need a Hospital in Nevada	*		
Unpaid CHS Bills Hurting Patients	*		
Needs Based Budget Process Should Continue	*		***
Recruitment/Retention of Health Providers	*		***
Welfare Reform, ACF, Enforce Implementation	*		***
Indian Desk at Office of Secretary DHHS	*		
Apply P.L. 93-638 to Other Agencies	*		

Bismark, North Dakota

Issue or Recommendation	Raised by One Participant	Raised by Several Participants	Crosscutting Issue
Importance of Continued Meaningful Consultation		**	***
Increase Funding for IHS		**	***
Alcohol Prevention		**	***
Increase CHS Funding		**	***
Strategic Health Planning Needed	*		
Adolescent Health and Adolescent Alcohol/SA Treatment		**	***
Elderly Care/Nursing Homes		**	***
Facilities Replacement		**	***
Regional Advocacy for Unique Needs of Plains Tribes		**	
Impact of Tribal Economy on Health	*		***
Fund Healthy Start and Child Health		**	
Increase Funding for Diabetes		**	***
Hold Federal Government Accountable		**	***
HCFA/Medicare Support for Tribal Nursing Homes		**	***
Increased Funding for Cancer Prevention/Treatment		**	
Catastrophic Health Costs and CHEF	*		***
Potential for “Means Testing” for Health Service Eligibility	*		
Anti-Indian Sentiment/Racism on the Rise		**	***
Need Long Term Commitment from Congress		**	***
Inequitable Allocation of IHS Funds to Treaty Tribes		**	
Increased Population, Increased Tribes		**	***
Reauthorization of the IHCIA	*		***
Final Rule for IHS Eligibility	*		***
Health Status Indicators in Plains States, Infant Mortality		**	
Indian Health Care Should be “Entitlement”	*		***
Increase in Chronic Diseases		**	***
Emergency Medical Services Needed		**	***
Traditional Healing Practices	*		***
Bad Roads and Transportation Needs	*		***
Increase in HIV/AIDS	*		***
Improve Influence with States	*		***
Honor Indian Treaties		**	***

Bismarck, North Dakota

Issue or Recommendation	Raised by One Participant	Raised by Several Participants	Crosscutting Issue
More Dependent on 3rd Party Billing	*		***
Amend HCFA Laws to Bill Outpatient Visits	*		***
Fund Contract Support Costs under 638		**	***
More Indian Health Professionals	*		***
Managed Care and Tribes, States, IHS, HCFA	*		***
Reauthorize IHCIA	*		***
Impact of Indians Returning from Urban Areas/Welfare Reform		**	
Put Funding into Block Grants	*		***
IHS as "Primary" Provider and not "Residual" Provider	*		
Water Pollution, Exposure to Hazardous Materials	*		***
Need More Staffing and Staff Housing	*		***
Treatment Needed for Methamphetamine	*		
Budget Formulation Process Concerns	*		***
USDA Commodities Program is a Part of the Problem	*		
Define "Tribes as States" to Access Other Funding	*		***
Address Mental Health Needs	*		***

Seattle, Washington

Issue or Recommendation	Raised by One Participant	Raised by Several Participants	Crosscutting Issue
Importance of Continued Meaningful Consultation		**	***
Joint Venture for Tribal Health Facility Construction	*		
Fund Mandatory Increases for IHS		**	***
Fulfill Federal Trust Responsibility to Provide Health Services		**	***
Diabetes Funding Needed		**	***
Increase Funds for Contract Health Services		**	***
Family Dysfunction Impacts on Health	*		
More Indian Health Professionals		**	***
Fulfill Indian Treaty Rights		**	***
Catastrophic Illness/Accidents not all Covered by CHEF	*		***
Elevation of IHS Director	*		***
Expanded Local Outpatient Clinics	*		***
Access Federal Tobacco Funds		**	
HCFA Rulemaking and Consultation		**	***
Reauthorization of the IHCIA		**	***
Inhalant Abuse Prevention and Treatment Needed	*		
Water/Sanitation Systems Needed		**	***
Social Service Programs Needed	*		
Child Welfare Funds to Tribes Rather than States	*		***
TANF Consultation Process		**	***
Patient Travel, Distance, Transportation		**	***
Self-Governance Funding	*		***
Elder Care		**	***
Alcohol and Substance Abuse		**	***
Fund Contract Support Costs (CSC)	*		***
Medicare/Medicaid Reimbursement, Outreach, Barriers		**	***
Equity in Funding from IHS/Actuarial Formula Needed	*		***
Head Start Funding	*		***
HCFA/IHS Memorandum of Agreement – Educate States		**	***
California Diabetes Funding Needs Review	*		

Seattle, Washington

Issue or Recommendation	Raised by One Participant	Raised by Several Participants	Crosscutting Issue
Need More Dental Providers and Dental Services	*		***
Health Services as an "Entitlement"	*		***
Traditional Healing Practices		**	***
Loss of Native Languages	*		
Need for Rehabilitation Programs	*		
Need Two Treatment Centers in California		**	
Modify Youth Treatment Law so Tribes can Contract Funds	*		
Elevation of the IHS Director	*		***
Increase Funding for large urban Indian Population in CA	*		
Support Existing Youth Treatment Centers	*		
Increase Indirect Rate for Head Start		**	
IHS/HUD Relationship on Environmental Health Issues	*		
IHS Sanitation Deficiency System	*		
SAMHSA Tribal Consultation Process Needed		**	***
Retroactive coverage for FQHC or IHS/HCFA/MOA	*		***
Direct Funding to Tribes for Child Welfare, Foster Care	*		***
TANF Federal Support for Infrastructure Needed		**	***
Share Research Findings with Tribes	*		***
NIH, CDC, Research – Development Local IRG's	*		
Protection of Civil Rights	*		
Extend Provision of P.L. 93-638 to other Agencies, ie Head Start	*		***
Lift he PL93-638 Contracting Moratorium	*		***
HRSA Tribal Consultation Needed	*		
No Indians on M/M Advisory Committee	*		
Base Closure Act, more Involvement for Tribes, Access	*		
Domestic Policy Council Involvement with Tribes	*		
Health Professions Scholarships Funds directly to Tribes	*		
Child Support Enforcement funds and process	*		
Family Preservation Discriminates against small tribes	*		
Consolidate DHHS funds into tribal block grants	*		
HCFA Work with States on Tribal Consultation	*		***

Oklahoma City, Oklahoma

Issue or Recommendation	Raised by One Participant	Raised by Several Participants	Crosscutting Issue
Importance of Continued Meaningful Consultation		**	***
Per Capita Funding for OK not Equitable with IHS		**	
Increase Total IHS Funding		**	***
Per Capita Funding for IHS not equitable with other programs		**	***
Increase Funding for Diabetes		**	***
Increase Funding for CHR		**	***
Increase Funding for Environmental Health		**	***
Increase Funding for EMS		**	***
Increase Funding for Pharmacy Services and Supply		**	***
Increase Funding for Elderly Care		**	***
Fund Dialysis Unit		**	
System to Serve/Reimburse for any IHS Eligible at any Site		**	
More Scholarships and Health Professions Training		**	***
New Hospital and Increased M/I for Lawton		**	
HCFA Consultation Process		**	***
Better Geographic Access to Facilities		**	***
Improve Medicare Billing for Tribes		**	***
CSC Funding and Cap on Indirect Costs	*		***
M/I Funds Needed for Facilities	*		***
FQHC Rates Declining to Only 70% of Costs	*		***
Lift Self-Governance Moratorium	*		***
Lift Moratorium on Eligibility Regulations	*		***
Elevate Director of IHS Position	*		***
Maintain Demonstration Status of OK Urban Clinics		**	
Increase Funding for OK Hospitals		**	
Funding for New Hospitals/Outpatient Clinics Needed	*		***
Extend FTCA and OMB Rates to Urban Programs	*		
Mental Health Professionals Needed for Increase in Suicides	*		***
Expand Public Health Nursing	*		***
Restore Community Health Nurse Training	*		
Establish and Indian Advisory Committee for DHHS	*		***

Oklahoma City, Oklahoma

Issue or Recommendation	Raised by One Participant	Raised by Several Participants	Crosscutting Issue
Provide Elderly Hospice Care	*		***
Impact of Contracting Claremore Hospital	*		
Problems with Medicare Paying for Home Health	*		***
Secretary of DHHS can/should waive Budget Act caps for IHS	*		
Need Inpatient Alcohol/Drug Treatment in Western OK	*		
Fairness Needed in Allocating Funds to Small Tribes	*		
Review Dental Eligibility and Treatment for Adults	*		
Increase Dental Funding	*		***
Quality of IHS Care at Stake, Long Waiting, Poor Care		**	
Access to VA Prime Vendor for Tribal 638 Programs	*		
Direct Billing of Medicare/Medicaid for Tribes	*		***
Funding Cuts to Child Care Bureau	*		
Funding for Head Start Facilities	*		***
No Jobs for Welfare Reform to Work	*		***
Tribal Access to other Agencies, NIH, CDC	*		***
Examine/Reduce Reporting Requirements	*		

Syracuse, New York

Issue or Recommendation	Raised by One Participant	Raised by Several Participants	Crosscutting Issue
Importance of Continued Meaningful Consultation		**	***
Funding Levels must Increase/Be Equitable		**	***
Alcohol and Drug Abuse Problems Increasing		**	***
Diabetes Increasing		**	***
Need more Funds for Contract Health Services		**	***
Water and Air Pollution Causing Disease		**	***
More Support for Prevention Initiatives		**	
HCFA Consultation Process Needed		**	***
Honor and Fulfill Treaty Obligations		**	***
International Border Problems with Child Custody Issues		**	
Medicaid Requirements Intrusive		**	***
Medicare Rates Needed for Referral Hospitals		**	***
M/M Reimbursement Rates Need Increase for Tribes		**	
States Not Recognizing, Cooperating with or Serving Indians		**	***
Funding for Contract Support Costs		**	***
Follow-Up Plans for Listening Council		**	***
DOJ Drug Courts a Working Model		**	
Misconceptions about “Gaming” and Taxation		**	
Indian Child Welfare and States Non-Cooperation		**	***
TANF Implementation		**	***
Elevation of the IHS Director Position		**	***
Need for Alcohol/Drug “Aftercare” Programs		**	***
Increase in Smoking	*		
Increase in Heart Disease	*		***
Increase in Cancer	*		***
Traditional Healing Practices	*		***
Longterm Elder Care	*		***
Increase in HIV/AIDS Patients	*		***
Dental Care for Children	*		***
Need for Radiology and Optometry Services	*		
Protection of Language and Culture	*		***

Syracuse, New York

Issue or Recommendation	Raised by One Participant	Raised by Several Participants	Crosscutting Issue
Community Youth Education	*		
Developmentally Disabled Children	*		***
Day Care Services for Infants and Toddlers	*		***
Services to Non Eligible patients and Lack of Funds	*		***
New Tribes Require New Funding	*		***
DHHS Flexibility Needed for All Programs	*		
Tribal Health Facilities	*		***
Health Professions Scholarships	*		***
MIS/Health Utilization and Health Status Data Lacking		**	***
Level Need Funded (LNF) Should be Looked at	*		***
OMB Consultation Process Needed	*		***
Impact on Funding Due to Compacting	*		***
Reauthorization of the IHCIA	*		***
IHS Should be an Entitlement	*		***
Loss of Medicaid Coverage and Increase in the Uninsured	*		***
Social Services Needed for Returning Families	*		
Indian Burial Sites are Being Distributed	*		
Fetal Alcohol Syndrome	*		
Local Racism Around Indian Land Claims	*		***
Tribes should have Own Congressional Representation	*		
No Information Out About DHHS Services/Programs	*		***
Need for “Wrap Around” Services	*		
Fulfill the Federal Trust Responsibility for Health Services	*		***
Catastrophic Illnesses and Lack of CHEF Funds	*		***

Acronyms

ACF:	Agency for Children and Families	**CSTE:**	Council of State and Territorial Epidemiologists
AHRQ:	Agency for Health Care Research and Quality	**DIR:**	Division of Information Resource
AI/AN:	American Indians/ Alaska Natives	**DP-HNES:**	Defined Population Health and Nutrition Examination Survey
ANA:	Administration for Native Americans	**DSH:**	Disproportionate Share Hospital Payments
AOA:	Administration on Aging	**EMS:**	Emergency Medical Services
ASMB:	Assistant Secretary for Management and Budget	**EPA:**	Environmental Protection Agency
BIA:	Bureau of Indian Affairs	**Epi Centers:**	Epidemiology Centers
CDC:	Centers for Disease Control and Prevention	**ESRD:**	End Stage Renal Disease
CHEF:	Catastrophic Health Emergency Fund	**FDA:**	Food and Drug Administration
CHR:	Community Health Representatives	**FQHC:**	Federally Qualified Health Centers
CHS:	Contract Health Services	**FY:**	Fiscal Year
CSAP:	Centers for Substance Abuse Prevention	**HCFA:**	Health Care Financing Administration
CSC:	Contract Support Cost	**HCUP:**	Health Cost and Utilization Project

Acronyms

HHS:	Department of Health and Human Services
HRSA:	Health Resources and Services Administration
IGA:	Office of Intergovernmental Affairs
IHCIA:	Indian Health Care Improvement Act (P.L. 94-638)
IHS:	Indian Health Service
IRB:	Institutional Research Boards
ISDEA:	Indian Self-Determination and Education Assistance Act (P.L. 93-638)
JCAHCO:	Joint Commission for the Accreditation of Health Care Organizations
LNF:	Level of Need Funded
MEPS:	Medical Expenditure Panel Survey
NCHS:	National Center for Health Statistics
NHIS:	National Health Interview Survey
NIH:	National Institutes of Health
OCSE:	Office of Child Support Enforcement
OMB:	Office of Management and Budget
OPDIVs:	Operating Division of HS
OPHS:	Office of Public Health and Science
PL:	Public Law
RFP:	Request for Proposals
RPMS:	Resource and Patient Management System
RYTC:	Regional Youth Treatment Center
SAMHSA:	Substance Abuse and Mental Health Services Administration
SLAITS:	State and Local Area Integrated Telephone Survey
STAFFDIVs:	Staff Divisions of HHS
TANF:	Temporary Assistance for Needy Families
USET:	United South and Eastern Tribes